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RECORD  
OF ONE TERM OF SERVICE  
IN  
THE SURGICAL WARDS  
OF THE  
GERMAN HOSPITAL  
OF  
PHILADELPHIA.

*presented by the author.*

BY  
J. WILLIAM WHITE, M.D.,  
ONE OF THE SURGEONS TO THE HOSPITAL.

FROM THE  
MEDICAL AND SURGICAL REPORTER,  
October 20, 1888.





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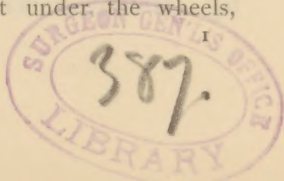
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BY J. WILLIAM WHITE, M.D.,  
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I desire to place on record, in as brief and concise a manner as possible, the most important of a series of cases treated by me during a term of service at the German Hospital, extending from the first of February to the middle of May, 1888. I do this because many of the cases are in themselves interesting and instructive, but especially with the wish of bringing before the profession through the columns of this journal the varied and extensive character of the surgical service in this hospital. I shall classify the cases rudely and confine myself to the most salient points, avoiding detail.

MODIFIED PIROGOFF AMPUTATION. P. D.,  
11 years old, while riding on the platform  
of a passenger train was thrown off, and  
fell with his left foot under the wheels,



sustaining a severe crushing injury of all the anterior portion of the foot, which necessitated amputation. As the tissues of the heel had escaped injury, I performed a Pirogoff operation omitting, however, the section of the lower end of the tibia and fibula, and placing the sawn surface of the os calcis in contact with the articular surface of the tibia, the former bone fitting closely between the external and internal malleoli. Cat-gut drainage was used through the posterior angles of the wound, and a small rubber drainage tube laid across its anterior portion. On the evening of the third day the temperature reached  $101.5^{\circ}$ . The stump was dressed and found in good condition. There had been but moderate oozing, and no retention of discharge. Next morning the temperature was normal, and so remained. Two weeks later the stump was again dressed, the drainage tube removed and the dressing reapplied. At this time there was slight motion of the os calcis upon the tibia, but the position was perfect. The stump was carefully dressed and, the sutures having been removed, it was allowed to remain without further inspection for three weeks, consolidation in such cases taking place more slowly than when two sawn surfaces are applied to each other. On removing the dressing at the end of this time the bones were found perfectly united, but the os calcis had a slight angle with the bones of the leg. Measurements on each side from the

anterior superior spinous process to the lower surface of the heel were precisely the same, and the little patient could walk without pain and almost without a limp. The union was so firm and the practical results so good that I made no attempt to straighten the angle which I have mentioned.

This case illustrates the excellent results which can be obtained by the modified Pirogoff operation when it is possible to insert the piece of calcaneum in the lower flap between the malleoli, the latter giving admirable support and preventing displacement either inward or outward. The opening of a second extensive surface of cancellated tissue—at the lower end of the tibia—is thus avoided, and this is worthy of consideration, though not of so much importance now as in the days when antiseptics were unheard of. The case also illustrates, however, one of the minor disadvantages of infrequent dressings. The slight motion which existed, at the time of the second dressing, permitted subsequent displacement; this remained unnoticed during the long period that elapsed before the next dressing, as it was not sufficiently marked to be observed through the bandages. The use of a splint would have made displacement impossible, and I shall either change the dressings oftener in my next case or employ a felt splint moulded to the posterior surface of the stump and ankle.

RESECTION OF ANKLE. R. D., 25 years old, while working in the Pencoyd Iron Works, sustained a compound luxation of the ankle joint, produced by a heavy bar of iron falling upon his foot. The internal malleolus was fractured on a level with the articulating surface of the tibia; the fibula was fractured two inches from the lower extremity; the soft parts were widely torn, and several inches of the tibia protruded from the wound. The vessels, with the exception of the dorsalis pedis, were intact, and the anterior portion of the foot in good condition. I enlarged the opening through which the tibia protruded and removed the internal malleolus, together with the lower extremity of the tibia. The lower fragment of the fibula was removed through a curved incision parallel with the posterior border of the external malleolus. I then with a Hey's saw removed the upper surface of the astragalus, brought it up firmly against the lower end of the tibia, placed two small rubber drainage tubes in position, one behind and one in front of the line of the union of the bones, brought the external wound together with silver sutures and put the whole foot and leg in a plaster-of-Paris dressing, leaving fenestra for the discharges to escape. In five weeks union was perfect with the exception of a small patch of granulations from the inner angle of the wound. The highest temperature was

reached on the evening of the seventh day, when it touched  $101^{\circ}$ . At this time the first dressing took place; subsequently the temperature continued to be absolutely normal.

In cases of which this is an illustration, the plaster-of-Paris splint is most admirable for the absolute fixation and immobility which it affords. When, however, on account of the soaking of the discharge it becomes necessary to remove the splint, it is very difficult to do so without considerable disturbance of the part. This, after excisions, is very objectionable, and I shall feel disposed at my next operation of the character just described to depend either upon the silicate dressing, which is more easily cut, or upon felt splints moulded to the limb.

AMPUTATION AT THE LOWER THIRD OF THE LEG. This was done in two cases, both of crushing injury received upon the railroad, one in a boy 10 years old, the other in a woman 60 years old. Both patients recovered without elevation of temperature, the highest in either case being  $100.8^{\circ}$ , and that on only one occasion.

AMPUTATION OF FIRST, SECOND, AND THIRD METACARPAL BONES AND THEIR CORRESPONDING FINGERS. This case was one of crushing injury of the hand from compression under the shaft of an engine. With a little difficulty, enough of the soft parts were preserved to make flaps for the

thumb and little finger, leaving a "lobster hand" which, however, proved to be very useful. There were only three dressings; no elevation of temperature.

**AMPUTATION AT THE WRIST JOINT.** In this case the entire hand was crushed between the bumpers of cars. The amputation was done at the wrist-joint, the styloid processes of the ulna and radius being retained. Union took place by first intention with only four dressings; there was no elevation of temperature. The stump was a useful and symmetrical one, and the amount of pronation and supination retained somewhat remarkable. Unless the styloid processes interfere with the application of an artificial hand (and I see no reason why they should), it would seem useless to remove them in this amputation, although the usual advice is to do so.

**AMPUTATION OF THE ARM.** In a case of railroad injury crushing the fore-arm, elbow, and lower arm, I amputated at the upper third by the musculo-cutaneous flap method. The soft parts were brought together in layers, the biceps and the brachialis anticus being first stitched to the triceps and then the skin brought together over the muscles by a separate row of sutures. I preserved some doubtful tissue in my desire to avoid going to the shoulder joint in this case, and as the result there was slight sloughing of the skin flaps, the temperature rising on one occasion to 103°.

With that exception there was no complication, and the patient recovered promptly with a symmetrical and useful stump.

ABDOMINAL SECTION. *Case I.* — Miss E. L., 38 years old, with a family history of tuberculosis, was well until she was 20 years of age when she met with an accident producing a severe contusion of the left ovarian region. This was followed by great tenderness, which persisted for a long period. Menstruation became very scanty, irregular, and exceedingly painful. Two years ago, after an acute exacerbation of the ovarian symptoms, there was a sudden and copious discharge of pus from the vagina, followed by temporary relief. Since then she has had symptoms of pelvic cellulitis, accompanied with pain in the right ovarian region, tenderness, and frequent discharge of pus. Oöphorectomy was performed May 8, and five weeks later she expressed herself as freer from pain than she had been for years. Recovery was rapid and interrupted only by the formation of a small stitch-abscess requiring evacuation. This kept the temperature for a few days in the neighborhood of  $100^{\circ}$ ; during the rest of the time it was normal.

*Case II.* — Mrs. E. B., 34 years old, presented herself with a large abdominal swelling, which had begun about one year before. It first appeared on the left side, afterward extending to the right; the pain in the early stages was extremely severe but

decreased as the tumor enlarged. The diagnosis of pregnancy was persisted in by a local physician up to the time of her admission to the hospital. I performed abdominal section on April 10, removing a multilocular cyst of the left ovary, which weighed, with its contents, about twenty pounds. As there was a small fibroid growth of the uterus, and as she had not yet reached her menopause, I removed the uterine appendages on the right side also. The second day after the operation her temperature reached  $100.5^{\circ}$ ; with that exception it remained normal. There was but one dressing; she was kept in bed for three weeks as a matter of precaution, and was discharged as cured.

*Case III.*—Mrs. S., 45 years old. She had a family history of cancer and tubercule. She had married when 16 years old, had nine children—twins once and triplets once, and had had four abortions. There was a laceration both of the cervix uteri and of the perineum. The patient had suffered much from dysmenorrhœa and menorrhagia, had had gout affecting the great toes in 1882, and later in the year an attack of right-sided hemiplegia, from which she slowly recovered. For some time past her chief difficulty had been from profuse and uncontrollable menorrhagia, accompanied with great pelvic and ovarian pain. Oöphorectomy was performed April 23; the patient recovered without a complication and left the hospital free from all symptoms.

*Case IV.*—Mrs. B., was admitted Feb. 3 with a large abdominal swelling, which had been twice tapped in the median line for what the physicians in attendance pronounced a multilocular ovarian cyst. An examination under ether rendered this diagnosis exceedingly doubtful in my opinion and in that of some of my colleagues. I determined, however, with their approval, to operate partly for the sake of exploration and partly to furnish drainage for the intraperitoneal exudation. It was found on opening the belly, that the case was one of encysted peritonitis. During the operation a second large cyst, not opened by the original incision, broke down under my finger and discharged a large quantity of turbid fluid.

A glass drainage tube was used, the peritoneal cavity irrigated with a warm boracic acid solution, and the wound sewed up. She did well for four or five days, but then died suddenly from a rapid extension of the peritonitis.

**HERNIOTOMY—RADICAL CURE.** *Case I.*—G. B., a farmer 49 years old, was admitted March 27 with a large swelling which occupied the right half of the scrotum; it was pear-shaped in form and was divided about mid-way between the fundus or base of the swelling and the line of Poupart's ligament by a transverse groove. The diagnosis of complete oblique inguinal hernia constricted in the sac was made without

difficulty, the symptoms—constipation, vomiting, etc., all pointing unmistakably in this direction. Herniotomy was performed, in regard to which the following interesting points may be noted.

1. The strangulation was in the sac itself, was due to the contraction of bands of lymph, and was exceedingly tight, so that with safety to the closely adherent bowel it was impossible to get the tip of a director beneath it. It was divided from without inward with delicate touches of the knife. As a consequence of the position of the constriction, the bowel contained in the upper half of the swelling—the part occupying the canal and the region of the external ring, was considerably swollen, reversing the usual shape of hernial swellings in having the larger portion above. The rings and canal were found largely stretched, and at these points the bowel was perfectly free. In the neighborhood of the contraction there were numerous adhesions between the bowel and the sac.

2. The knuckles of gut below the constriction were found to be black, cold, offensive in odor, and crepitating when handled. It did not seem possible at first sight that they could recover themselves, but a half-hour's delay, during which time they were allowed to rest upon the upper surface of the thigh covered with hot carbolized towels, so improved their condition in every respect that it was deemed safe to return them to the abdomen.

3. The sac contained an exceedingly large quantity of fluid. Within the sac was found a body about the size of the last joint of the thumb, glandular in structure and with a fleshy rounded cord running up from it through the inguinal canal. This cord contained a hard wire-like body which slipped from between the fingers when handled. At first the fluid was thought to be that of a hydrocele and the glandular body to be an atrophied testicle with the accompanying spermatic cord and vas deferens. In other words, it was thought that the hernia was of the congenital variety. A little further investigation, however, revealed both testicles *in situ*, and a more careful examination showed that the gland was one of the mesenteric group; the supposed vas deferens proved to be an enlarged hardened lymphatic vessel, and the fleshy mass surrounding it a portion of omentum which had been much altered through its long sojourn outside of the abdomen. The hernia had been irreducible for years.

4. After the removal of this piece of omentum and ligation of the neck of the sac, the sac itself was excised. The fundus of the sac, which was tightly adherent to all the scrotal tissues, was left in place. The different layers of the abdominal wall on each side of the wound were first stitched together with cat-gut, and then the two broad fleshy walls thus obtained were united by silver sutures, cat-gut drainage being used.

The lower third of the wound was left open and was packed with strips of iodoform gauze. The patient recovered; only a few drops of pus formed, the temperature was normal after the second day, only three dressings were necessary, and the hernia was cured (?). Three months later there had been no return.

*Case II.*—T. B., a man 19 years old, was admitted May 5 with a strangulated hernia of the right side, complicated with a retained testicle. The hernia was of the congenital variety, attacks of strangulation were frequent, and the presence of the testicle in the canal rendered the use of a truss almost impossible. The testicle was found atrophied, and was therefore removed. The sac was ligated and excised and the wound treated as in the case just described with the exception that as the whole sac was removed no portion of the wound was left open. Union occurred by first intention—no fever, no pus. Apparent cure two months after the operation.

**CONCUSSION OF THE BRAIN—CEREBRAL LOCALIZATION.** J. Mc., a man 45 years old, a laborer, was admitted May 3, in a semi-unconscious condition; there was a history of his having fallen sixteen or eighteen feet from a tree, striking upon his head. There was a slight ecchymosis in the left temporal region.

A horse-shoe shaped flap of the scalp was raised for exploratory purposes. No depres-

sion or other evidence of fracture of the skull could be detected, and the flap was replaced. The patient had at that time all the characteristic symptoms of concussion of the brain, together with complete aphasia. When disturbed, he moved all his limbs in the effort to return to the position which he preferred, which was that characteristic of cases of concussion—a lateral decubitus with the legs flexed on the thighs, and the thighs on the abdomen. In about forty-eight hours it was observed that his right leg became motionless and helpless, and in the course of two days more he ceased to use his right upper extremity and no voluntary movement in it could be elicited. I then thought the case was one of rupture of one of the smaller posterior branches of the middle meningeal artery, either from fracture of the internal table, or from the direct result of the injury. The symptoms pointed to a slowly forming clot, creeping upward along the Rolandic line and involving successively the centres for speech, for the lower limb, and for the upper limb. I called a consultation of my colleagues for the following day with the intention of trephining. By the time we met, however, he had begun again to move the right arm and it was decided to wait and watch developments. In a day or two more movement returned in the right leg and before the end of the week he for the first time answered questions and spoke now and then spontaneously. He steadily

improved in all respects passing, however, through a period of dementia, during which time he was filthy in his personal habits and occasionally destructive, breaking up his furniture in order to obtain pieces of wood to chew, etc. After recovering sufficiently to be of use about the hospital, he absconded, though still in a condition of feeble intellect.

COMPRESSION OF THE BRAIN; CEREBRAL LOCALIZATION. A. B., a man about 60 years of age, was admitted in the afternoon of March 14, having also fallen from a tree, striking upon the side of the head. He was unconscious, with all of the symptoms of compression of the brain. There was a scalp wound, which, upon being slightly enlarged led down to sound bone. It was situated behind the parietal protuberance. The only paralysis which was noticeable was facial. As it was clearly a case for trephining, or at least for exploring the skull with that object in view, and as the existing scalp wound threw no light upon the condition, I carefully mapped out upon the scalp the area indicated by the facial palsy and punctured the scalp with a bistoury to indicate the precise point at which I expected to find the brain lesion. A large flap was then raised, and within one-eighth of an inch of my puncture was found a splintered fracture of the skull, with laceration of the brain substance. After beginning the removal of the fragments, the fracture

was found to have extended through the inner table in the whole temporal region. The meningeal artery had been wounded and required ligature; the line of fracture extended to the floor of the middle cerebral fossa, but the only point at which brain substance had been actually wounded was at the locality mentioned. The patient never recovered consciousness, but died within a few hours of shock.

**SHOULDER-JOINT AMPUTATION.** A. B., 28 years old, was run over by a train which crushed his entire right arm to within a few inches of the shoulder. The hemorrhage had been great, and on his admission he was severely shocked and almost bloodless, showing very little disposition to react. I decided, however, to give him the chance and performed a shoulder-joint amputation, keeping him alive while so-doing by elevation of the extremities, dropping the head over the edge of the bed and using hypodermics of ether, whiskey, and digitalis, and of hot saline solutions. He appeared to re-act very well for an hour or two, and then died suddenly of heart failure. I have regretted since that I did not transfuse directly into a vein, employing either blood, or a saline solution; I shall certainly do so in the next similar case I have.

**EXCISION OF THE KNEE; DOG BONE PEG USED.** S. C., 22 years old, with a family and personal history of tuberculosis, was admitted to the hospital on May 18, for chronic

arthritis of the knee-joint. As immobilization produced no favorable change I performed excision some weeks later, removing a section of the tibia and femur and carefully scraping out the carious cavities which I found in both bones. In bringing them together I used as a bond of union the metacarpal bone of a dog. This had been freshly removed with all antiseptic precautions. It answered very well mechanically, keeping the bones in excellent position ; but it was, so far as I could see, of no other special advantage. (This case is reported in detail with remarks on the general principles of bony union, in the *Lancet*, August 18, 1888.)

**BULLET WOUND.** E. D., 23 years old, was admitted March 28 with a bullet wound situated just to the left of the symphysis pubis. After a little search the ball was found to have taken an upward direction and to have lodged in the scrotal tissues just below and in front of the bulbous portion of the urethra. It was extracted by a dissection which bi-sectioned the lower portion of the scrotum. The urethra was not opened. Cat-gut drainage was used and recovery was uninterrupted.

**TRANSVERSE FRACTURE OF THE PATELLA.**  
**THE ASEPTIC USE OF MALGAIGNE'S HOOKS.**  
 E. H., 30 years old, fell while getting on a train which was in motion, and in the attempt to save himself sustained a transverse fracture of the patella, through muscular action. It was immediately followed

by great swelling of the joint and entire disability. A few hours later, with the most careful antiseptic precautions the joint was aspirated, several ounces of bloody fluid being removed; I then brought the bones together from a separation of more than three inches, using Malgaigne's hooks and passing them directly through the soft parts. Irrigation with bichloride was kept up during the operation and the knee was dressed antiseptically, the hooks being included in the dressings. There was no elevation of temperature, and but two dressings in five weeks. At the end of that time the hooks were removed, the line of apparent union between the fragments being scarcely perceptible. The vertical diameter of the patella was the same in both limbs. A posterior splint with the figure-of-eight bandage was applied, and the patient cautioned against undue movement. He, however, kicked around freely in bed and somewhat displaced his dressings, and a few days later I found a separation of the fragments to the extent of perhaps three-eighths of an inch. He was again placed on a posterior splint with a firm figure of eight bandage. He recovered with good fibrous union, and no further separation of the fragments.

**VESICAL CALCULUS; SECONDARY PYONEPHROSIS.** J. P., 30 years old, was admitted April 3 with a history of long standing vesical calculus. This history was easily confirmed on examination, when I found that the stone

was probably of extremely large size, and therefore decided upon the suprapubic operation, to which the patient consented. He was extremely weak and had a profuse dysenteric diarrhoea. The night before the day fixed for the operation, he suddenly died and the autopsy, which I conducted the following afternoon, showed a condition of the kidney which made it marvelous that he had lived so long. The entire secreting structure had disappeared and the organs were transformed into multilocular sacs containing enormous quantities of muco-pus. The ureters were dilated to almost the calibre of the small intestine. The bladder contained a calculus weighing 532 grains. The origin of this dilatation of the ureters and kidney in such cases is of great interest, as no appreciable obstacle to the entrance of urine into the bladder is usually discoverable. It seems probable that in some instances the dilatation is brought about by the frequent contraction of the walls of the bladder, each act of this character temporarily interrupting the flow of urine through the vesical end of the ureter. This, taken in conjunction with the extension of inflammation from the bladder by continuity, probably explains the condition. An operation would have been certainly fatal, and I was thankful to have escaped the additional risk of death during the use of ether. The urine was so loaded with vesical *débris* that the condition of the kidney could not be

accurately determined in advance of the operation.

**EXOSTOSIS OF HUMERUS.** F. R., 12 years old, had an extensive exostosis of the left humerus, at the point of insertion of the pectoralis major and growing quite rapidly. It was entirely removed through an incision parallel with the bone, bone forceps and a chisel being employed. He recovered promptly.

**PSOAS ABSCESS.** F. S., 48 years old, was admitted April 20, with the following history. He had never been seriously ill until 1884, when he had an attack of malarial fever which confined him to a hospital for seven weeks. About a year ago he noticed a slight pain on the left side of the pelvis, and about the sacro-iliac juncture. This gradually increased, so that he was unable to perform his work. Last August he first noticed a swelling in the upper portion of Scarpa's triangle. This markedly increased until, when he came to the hospital, it occupied almost that entire region. The swelling was soft, fluctuating, and without *bruit*; there was a slight apparent pulsation, but it was not centrifugal and was merely the upheaval of the mass produced by the femoral artery lying beneath it. As the man was totally disabled and was rapidly losing strength and flesh I evacuated the abscess with full Listerian precautions. It contained an enormous quantity of pus, between one and two gallons, and continued for a

short time to discharge freely. It was dressed daily and contracted rapidly, it being necessary at each dressing to shorten the drainage tube. When I last saw him he seemed almost entirely recovered.

#### RUPTURE OF BLADDER AND URETHRA.

W. B., 38 years old, while coupling cars on the Reading railroad was caught laterally between the bumpers, the pressure being applied about equally on both sides from the trochanters to the crest of the ilium. He was admitted May 7, complaining of great pain over the right horizontal ramus of the pubis, at which point crepitus could be felt distinctly. He had moderate symptoms of shock. On catheterization a small quantity of bloody urine was obtained. The following day the abdomen became somewhat distended, but the urine gradually became clearer and the bladder more tolerant of it, until at the end of the fifth day the patient passed spontaneously from four to six ounces of perfectly clear urine. His temperature being then in the neighborhood of  $100^{\circ}$  and his belly flat and painless, I hoped that the source of the blood had been an unimportant rupture of the urethra. Catheterization was stopped and the patient kept on general supporting treatment. He however gradually developed septic symptoms, and two or three days later, upon the appearance of œdema of the lower portion of the abdomen and the upper part of the thighs, I dissected down and opened the

cavity of the pelvis just above the ramus of the pubis, finding it filled with pus and with rapidly disintegrating sloughs of the sub-peritoneal connective tissue. Drainage and irrigation were employed, but without avail; the man died on the 17th, ten days after the injury. The autopsy showed a rent in the bladder wall, and another not very extensive one in the membranous urethra. That in the bladder showed an attempt at union of the edges, and it would seem possible that some such union by adhesive inflammation took place early in the case, at about the time the blood disappeared from the urine and the bladder became retentive. Undoubtedly, however, some pelvic extravasation had occurred before this time, but the absence of any general or local phenomena pointing to it was truly remarkable. A continuance of the abdominal distention, high temperature and scanty urine would have led to an exploratory operation; but the subsidence of all these symptoms seemed to make an operation unjustifiable, although it was carefully discussed.

**LYMPHADENOMA WITH A HISTORY OF HERNIA.** B. S., 61 years old, was admitted with the history of the sudden appearance of a tumor just below the line of her left groin, and accompanied with local pain, constipation, vomiting and mild shock. The tumor, she insisted, was precisely similar to one from which she had suffered some years before, and which, she said, the doctor who

attended her had caused to disappear by handling. In this history she persisted in spite of careful cross-questioning. The tumor was about half the size of the fist, situated over the saphenous opening, tense and apparently exquisitely tender, so that she could not bear to have it palpated. It was dull on percussion and had no impulse on coughing. She was etherized, when it was found that the tumor was distinctly lobulated. A diagnosis of lymphadenoma was made, though it was thought possible, in view of the history, that there might be a small femoral hernia strangulated in the canal. The growth was cut down upon and removed, but I found there was no trace of a hernial protrusion of any sort. The case is interesting on account of the conflict between the history and the actual condition.

**HEMORRHOIDS.** In a case of extensive hemorrhoids in a woman 60 years old, the old operation of ligation was performed. The tumors were left protruding and were dusted daily with iodoform, which is, in my opinion, *the* antiseptic for all operations about the anus. The patient was entirely well in less than two weeks, in spite of her age and of the extensive size of the piles. There was no fever and no development of unpleasant odor after the operation.

**EPITHELIOMA.** In a case of extensive epithelioma of the lower lip a large portion of

the lip and of the soft tissues from the front of the chin was removed. It was found that there was in addition considerable disease of the alveolar process of the inferior maxilla, and I therefore, at the same time, extracted the right lateral incisors, the canines, and the bicuspid, and removed one-half the lower jaw, leaving its lower edge to preserve the contour. There was almost no fever, except for a few hours when a slight erysipelatous blush, the result of tension, made its appearance. The patient was discharged cured in about two weeks.

In addition to these cases, most of which were operative, I may summarize briefly the history of others which came under my care during the three months term of service, many of which were no less interesting. There were ten cases of compound fracture of various bones; in eight of these the highest temperature reached was  $100^{\circ}$ . In the other two there were other injuries, extensive contusions and subsequent cellulitis, which ran the temperature up for a few days. They all recovered, and all with useful limbs. Of other fractures I may note that in eleven cases of fracture of one or both bones of the leg the average time of stay in the hospital was not more than five weeks. The remaining fractures were simple ones, and included six of the femur, several of the ribs, two of the pelvis (one of which recovered), and numbers of the arm, forearm, and other bones. There were twelve

cases of burns and scalds, some of them very extensive. All recovered except one, a woman 60 years old, who died of delirium tremens. Of miscellaneous and unclassifiable cases—contusions, luxations, lacerated wounds, minor abscesses, ulcers, idiopathic erysipelas, urethral stricture, and inflammation, carbuncle, chilblains, necroses, cystitis, sprains, syphilis—there were in the neighborhood of 60 cases, which were worthy of record but which can not be condensed or abstracted without too greatly increasing the length of this paper, the chief object of which will be attained if it serves to call attention to the excellent and extensive charitable work which is being done by the President and Board of Managers of the German Hospital.

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